SPECIAL ADVISORY COMMITTEE
ON
ETHICAL ISSUES IN HEALTH CARE

INSTITUTIONAL ETHICS COMMITTEES

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Ethical problems and decision-making are inherent in medical care and the patient/family/physician/institutional relationship. Questions arise from advances in medical technology, from the desire to provide optimum outcomes within an environment of fiscal restraint, and from changing social values and relationships. In the past, ethical issues have been dealt with indirectly by committees and by policy statements. More recently, ethics committees have developed within institutions as a multidisciplinary group established specifically to address ethical dilemmas and education within the institution. By providing a forum for discussion of varied perspectives and concerns on particular cases and learning as the focus for institutional ethics education, the ethics committee fosters open debate about sensitive issues leading to improved decision-making and better relationships. Most importantly, existence of an ethics committee contributes significantly to an institutional culture that fosters ethical attitudes.

Many hospitals and long-term care facilities in British Columbia now have ethics committees. The 1991 Canadian Council on Health Facilities Accreditation standards require the governing body of facilities to establish a process for addressing ethical issues and have policies on specific ethical matters. Provincial experience confirms that the process of getting a committee going and confident is slow, that procedures within committees may be uncertain, and that purpose, function and accountability are constantly in review. Nonetheless, the success of these committees in serving patient interests is apparent.

Each institution will respond uniquely to the demand for more thought about critical health care issues. Nonetheless, there are certain aspects common to all ethics committees that are helpful to know for those considering the matter for the first time and for those reviewing past accomplishments.

Structure and Organizational Placement

Ethics committees can be lodged within the medical staff, the administration or the governing board structure of the facility. The position of the committee within the organization's structure may affect concerns of confidentiality of patient records, committee procedures, and membership and liability protection. The structural placement of an ethics committee makes a strong statement about its role and function.

By placing the committee with the board, the message is that ethical concerns are those of the facility as a whole and not primarily questions of concern to the medical staff and administration. Placement with the board ensure legal protection from disclosure for its records and its members. A board committee also serves to equalize the status of all members of the committee, thus minimizing the sometimes troublesome institutional hierarchical structure.

Placement within the medical staff will enhance the importance of ethical issues for physicians and may give them greater confidence to participate. However, the governing body retains responsibility to ensure that ethical issues are appropriately addressed. This may be accomplished by regular reporting to the board and by board appointment of members and the chairman.

On balance, the ethics committee is best situated as a committee of the board with terms of reference that specify participation of the medical staff and that require reporting to both the board and medical staff. This situation will best assist the committee to maintain a neutral, balanced role. The duties of the committee should include a liaison role between the board and medical staff on ethical issues. In this way, the direct responsibility of the board to ensure a process for addressing ethical issues is satisfied while preserving legal protection and maximizing medical staff involvement.

It is appreciated that small institutions and communities may find it difficult to establish an ethics committee because of the lack of trained personnel and time constraints for professional participants. Regional hospitals should act as a resource for smaller institutions by providing assistance in the crucial start-up phase, sharing ethics literature and developed policies, and providing knowledgeable personnel if appropriate. Regional hospitals could play a liaison role to local hospitals by referral of certain issues upon request. Assistance may also be sought from the Centre for Applied Ethics at U.B.C., ethics instructors at B.C.'s colleges and universities, and the teaching hospitals.

B.C.'s provincial committee, the Special Advisory Panel on Ethical Issues in Health Care, provides policy statements on ethical issues. As a committee, it does not offer advice on specific cases of institutional issues, although its members may, from time to time, serve as speakers or special consultants to facilities and health care organizations.

Membership

In order to be credible both within and without the institution, membership on the ethics committee should be representative of the public, of the health care community, and of the institution. The largest proportionate representation may be physicians who, while often not knowledgeable in ethics, will provide the important scientific and technological information and identify and describe issues within the physician/patient relationship. Nurses also will play a significant role in placing issues within the patient's practical reality and the institution's persona. Administrative representation on the committee will facilitate the work of the committee and provide information on institutional ability to respond to alternative considerations.

There are other professionals whose knowledge the committee may need. Lawyers, social workers, administrators, ethicists, and chaplains all may provide an important perspective. This is especially so with the expansion of expertise requirements to include economics and finance. Individuals should be selected who are not in a conflict of interest and who may have some knowledge of ethics and the ability to respond to ethical analysis. As in all appointments, the person must have the time for committee work, the temperament for reflective analysis, and tolerance of other views.

Ethics committees should consider having lay members. While it may take awhile to get organized and to realize how lay members may help, there are advantages in terms of community input and credibility. "Lay" usually means someone who is not a health care professional and who may not be employed by the institution.

The number of members should be determined by the size and complexity of the facility. The chair of the committee should be carefully chosen for the ability to establish a trusting, open, non-partisan, and cooperative working relationship among the members. Medical, nursing, administrative and other staff members should be chosen, not because they may hold positions of leadership within the facility or their respective professions, but because they have the respect of their colleagues and the abilities described above.

Purpose and Function

The purpose of an ethics committee is directly related to the service(s) the facility provides. The committee's terms of reference must be closely tied to the facility's mission statement. Ethics committees are consultative committees and therefore do not have decision-making powers.

Ethics committees do not substitute for or usurp the authority of the various review bodies within the facility or the professions, nor do they take the place of physician judgment. Ethics committees should be advisory only, acting as a sounding board for concerned health care providers and providing a forum for broader discussion and consensus building.

All members of the facility community - nurses, physicians, administrators, pastoral care workers, the board, patient advocates and other staff - are responsible to ensure that ethical issues are addressed within the institution. Each should have access to the services of the committee. Each should be be welcomed and appreciated if they present or raise questions for inclusion on the committee's agenda. It is important that ethics committees resist taking on the role of facility ombudsman; this role is well beyond their terms of reference.

The primary functions of the ethics committee are education, policy and guidelines recommendations, and case review.

a) **Education**

Education is the most important function of an ethics committee. This includes education of the committee itself, the facility community (staff, patients and/or residents) and the general public. The first educational focus should be on the committee itself, the members of which may be unfamiliar with ethical issues and theory. This initial training, along with development of an understanding of the role of an ethics committee, may thoroughly envelop the committee in the first months or even years of operation. After educating the committee, the greatest educational concern is to enable health providers to identify a situation as raising an ethical dilemma and to make them aware of the services of the committee. This involves reaching to all providers through participation in rounds, meetings and seminars, expansion of library services to include ethics materials, and distribution of ethics policies. Attempts to educate the general public should emphasize the existence of a process for ethical review within the facility, keeping within the abilities and resources available to the committee.

b) Policy and Guideline Recommendations

Ethics committees should review the facility's policy statements and guidelines. They may recommend changes to existing documents and initiate the development of new policies and guidelines. At the very least, hospitals should have ethics policies which address the issues of consent, choice, and accessibility and refusal of treatment, death and dying, abortion, research, patient's complaints and organ donation and retrieval. These should be regularly revised. The committee should work with other facility personnel and committees to ensure the dissemination and availability of these policies to all affected health care providers.

c) Case Review

The most controversial function of ethics committees is case review. Fear is expressed that the ethics committee will interfere with the doctor-patient relationship and either directly or indirectly assume decision-making authority for treatment. Most cases are resolved by team consultation without referral to the ethics committee. Inevitably, it is only the most difficult cases that go before the committee. For this reason, ethics committees should proceed very cautiously with case reviews. If possible, this function should be delayed until the role in education and policy review has been aptly demonstrated to the facility's physicians and the board.

Ethics committees can be valuable in identifying misunderstandings and untangling communication blockage related to treatment policies and guidelines. When reviewing cases, ethics committees are concerned with ethical problems in the clinical care of patients. They are responsible for considering the ethical nature of the medical and other patient care decisions.

In order to foster openness of ethical review, equality of access to the committee, and voluntariness, requests for case review should be made directly to the chairperson of the committee by any member of the facility community. The chairperson is in the best position to initially assess the situation and determine whether the matter should be dealt with by the committee or referred elsewhere for further elaboration and consultation. The chairperson should report to the committee on all requests received so that the committee may ultimately determine if the matter was handled appropriately. If the chairperson decides to bring the matter to the committee immediately, the most timely method must be chosen for the committee to review the case. In urgent circumstances, an emergency meeting of the committee can be arranged quickly, sometimes using telephone conferencing.

In order to properly assess a case, the ethics committee should be provided with a complete medical review by all attending and consulting physicians so that diagnosis and prognosis are as clear and certain as possible. The attitude of the family should be made known and the input of nurses and social workers associated with the case sought as required. A literature review should be available if proposed treatments are medically controversial. This informational protocol should be established prior to the initiation of case reviews.

Following case reviews, retrospective analysis should be an ongoing process. The committee may conclude that procedural improvements should be made, that referral to other committees is appropriate, that research should be undertaken, or that policy directives or guidelines are required. This anlaysis will form a basic educational tool for the committee when it comes to review another case.

Summary of Recommendations

1. Hospitals and long-term care facilities should have an ethics committee established to guide the institution in addressing ethical issues.

2. The ethics committee should be a committee of the board of Directors with terms of reference that specify participation of the medical staff and that require reporting to both the board and the medical staff.

3. The purpose of the ethics committee is to act as a liaison between the board and medical staff on ethical issues, promote ethical education within the facility, develop policy and guidelines recommendations on ethical matters for discussion within the institution, and review specific cases upon request.

4. Membership on the ethics committee should include members of the medical, nursing and administrative staff, as well as other professionals whose perspective may be beneficial. Lay persons who are representative of the community may be added once the committee is established.

5. The ethics committee should consider its primary role to be education and should develop a strategy for ethics education within the institution.

6. Policy development should address the issues of consent to and refusal of treatment, choice and accessibility of treatment, death and dying, abortion, human research, patients' complaints, and organ donation and retrieval.

7. Case review should only be initiated once the committee members are confident of their educational ethics training and following establishment of an access and information protocol for case review.

Recommended Reading

1. Canadian Hospital Association, Institutional Ethics Committees: Recommendations for Action, Ottawa, 1986.

2. Canadian Hospital Association, Current Issues in Health Care: A Planning Proposal for Institutional Ethics Committees, Ottawa, 1986.

3. Ross, Judith Wilson, Handbook for Hospital Ethics Committees, American Hospital Association, 1986.

4. Cranford, Ronald E. and Allan, Evelyn J., "The implications and applications of institutional ethics committees", American College of Surgeons Bulletin, 70:6, 19 (June, 1985).

5. Cohen, Cynthia B., "Interdisciplinary Consultation on the Care of the Critically Ill and Dying: The Role of one Hospital Ethics Committee", Critical Care Medicine, 10:11, 776 (November 1982).

6. "A Decade of Ethics Committees: A Time for Recommitment and Evaluation", Hospital Ethics, 6:3, 4 (May-June, 1990).

7. Rawlins, Timothy D. and Bradley, John G. "Planning for Hospital Ethics Committees: Meeting the Needs of the Professional Staff", Hospital Ethics Committee Forum, 2:6, 361 (1990).

8. Stidham, Gregory L., Christensen, Kate T., Burke, Gerald F., "The Role of Patients/Family Members in the Hospital Ethics Committees Review and Deliberations", Hospital Ethics Committee Forum, 2:1, 3 (1990).

9. MacDonald, Julie, Smith, Shirley A., Winter, Robert J. "To What Extent Should a Hospital Ethics Committee Be Involved In Hospital Policy Formation?", Hospital Ethics Committee Forum, 1:6, 341 (1989).